

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

12085

Reg. Dist. No. 21

1. PLACE OF DEATH:

County ARUNDEL
 City or town ANNAPOLIS, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 HRS.
 Hospital, institution, or street address where death occurred:
EMERGENCY HOSPITAL
 How long in hospital or institution? 7 HRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD. County ARUNDEL
 City or town ANNAPOLIS
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. CARVEL HALL
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

GERTUDE EVERETT BALDWIN

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife RICHARD BALDWIN

7. Birth date of deceased (mo., day, yr.) MAY 16, 1868 6. (c) If alive, give age years

8. AGE: Years 80 Months 6 Days 19 If less than one day hrs. min.

9. Birthplace NEW YORK CITY
 (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

12. Name WILLIAM W. EVERETT

13. Birthplace MD.

14. Maiden name GEORGIANA KELLEY

15. Birthplace N.Y.

16. Informant C. C. BALDWIN

Address 808 26TH ST SO. ARLINGTON VA

17. BURIAL Date thereof 12 7 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BALDWIN MEMORIAL

Location MILLERSVILLE, MD.

18. Funeral director HENRY W. JENKINS & SONS

Address 4905 YORK RD. BALTO 12

19. Dec 6 48 P.M. Hedush
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 19 48, at 12:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 47, to Dec 5 19 48

and that I last saw him alive on Dec 5 19 48

Immediate cause of death Central

hemorrhage DURATION 7 hrs

Due to arteriosclerotic cardio-

vascular disease & 1572

Due to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Broun M. D. or other

Address Annapolis Md Date signed 12/15/48

Borsuck

Amos Lane # at Brookline Ave 2760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 226 Thaw
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Ralph Bauer

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Pearl Bauer

7. Birth date of deceased (mo., day, yr.)

Jan 19, 18956. (c) If alive, give age 54 years

8. AGE:

53 Years11 Months2 Days

If less than one day

hrs.

min.

9. Birthplace

Lykensville, Carroll Co., Maryland
(Town, county, and state)

10. Usual occupation

garage man

11. Industry or business

U. S. Naval Academy

MOTHER FATHER

12. Name

John H. Bauer

13. Birthplace

Belair, Harford Co., Maryland

14. Maiden name

Ella E. Stagner

15. Birthplace

Belair, Harford Co., Maryland

16. Informant

Mrs. Pearl Bauer

Address

226 Thaw St. Annapolis, Md

17.

Burial
(Burial, cremation, or removal, which?)

Date thereof

12/23/48
(month) (day) (year)

Cemetery or crematory

Cedar Bluff

Location

Annapolis, Md

18. Funeral director

T. A. Henderson & Son

Address

Beltsville, Md

19.

Dec 22, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 21, 1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination
and that I last saw him live on Dec 21, 1948

Immediate cause of death

Acute Cardiac Failure

DURATION

sudden

Due to

Chronic Cardio-vascularabout

Due to

disease4 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

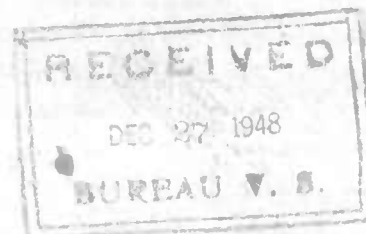
Injured at work?

23. SIGNATURE

John M. Caffy, M.D.
M. D. or other

Address

Annapolis, Maryland Date signed 12-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 PIECES OF EVIDENCE
CHANGE OF AGE SHOWN ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *28*

1. FILM NO. *G 118* JAN 19 1949
2. FILM NO. *118* JAN 19 1949

1. PLACE OF DEATH:

County *Anne Arundel*
City or town *Crownsville*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *11 years, 15 mos. 28 days*
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? *11 years, 15 mos. 28 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore City*
City or town *Baltimore City*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *unknown*
(If rural, give LOCATION)
2.(a) If veteran, name war. ☒

3. (a) FULL NAME

BLANCHE BISHOP

3. (b) Social Security Number

4. Sex *FEMALE* 5. Color or race *Colored* 6.(a) Single, married, widowed, or divorced *single*
6.(b) Name of husband or wife *none*
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) *1896*
8. AGE: Years *58* Months *5* Days *?* If less than one day *?* hrs. *?* min.

9. Birthplace *Maryland town unknown*
(Town, county, and state)
10. Usual occupation *Housework*
11. Industry or business *none*

12. Name *John Bishop*
13. Birthplace *Maryland town unknown*
14. Maiden name *Julia Cook,*
15. Birthplace *Maryland*

16. Informant *Hospital Records*
Address *Crownsville, Maryland*
17. *burial* Date thereof *1/1-49*
(Burial, cremation, or removal. When?) (month) (day) (year)
Cemetery or crematorium *Hospital*
Location *Crownsville Md*
18. Funeral director *Sup. Hsptl.*
Address *Crownsville Md*
19. *1/1* *49* *ET Joyce Poole*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *12/16/48* *1948* at *1:30 A.M.*
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *9/18/37* *1937* to *12/16/48* *1948*
and that I last saw her alive on *12/16/48* *19*
Immediate cause of death *Hypertensive*
Cardio-Vascular Disease

Other conditions *Chronic Alcoholism*
Epilepsy
(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE *Jacob M. Mays* *M.D.*
Address _____ Date signed _____

DURATION
known to
us since
9/18/37

RECEIVED

JAN 4 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cover page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 121188

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7/12/48
 Hospital, institution, or street address where death occurred:
Crownsville State Hos pital
 How long in hospital or institution? 5 ms 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town 1069 Argyle Ave. Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____

3. (a) FULL NAME

LUCY LEE BLAKE

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race COLORED 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Frank Bla ke
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 3/4/1878
 8. AGE: Years 70 Months 9 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business _____
 12. Name James Woods deceased
 13. Birthplace Blacksburg Va
 14. Maiden name Sarah Woods deceased
 15. Birthplace Blacksburg Va.

16. Informant H ospital-records
 Address Crownsville State Hospital
 17. Burial Date thereof 12/30/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory mt Auburn
 Location Balto. Md
 18. Funeral director Chas. Harper
 Address 512 Carrollton Ave
 19. 12/30 19 48 AW Hedrick
 (Date rec'd by registrar) (Registrator)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25/48 19____ at 0910 M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7/12/48 19____ to 12/25/48 19____
 and that I last saw h er alive on 12/25/48 19____
 Immediate cause of death
myodegeneration cordis
cerebral arteriosclerosis
moderate diabetes
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Jacob Muncaster M.D.
 Address _____ Date signed _____

DURATION
known
to us
since
7/12/48.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel
 City or town Linthicum
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
200 - Benton Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md. County C-D.
 City or town Linthicum Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hammond Rising Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Caroline Virginia Brown

3. (b) Social Security Number

4. Sex F. 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife William L. Brown.
 6. (c) If alive, give age dead years
 7. Birth date of deceased (mo., day, yr.) July 20 - 1873

8. AGE: Years 75 Months 5 Days 5 It less than one day
 ..hrs.min.

9. Birthplace Harage, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name Randolph Young
 13. Birthplace Howard Co., Md.
 14. Maiden name Sarah F. Johnson
 15. Birthplace Howard Co., Md.

16. Informant William L. Brown, Jr.
 Address Linthicum, Md.

17. Burial Date thereof Dec. 19, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location BROOKLYN, Md. R.F.D.

18. Funeral director Thomas W. Duffin

Address Glen Burnie, Md.

19. 12/22 48 L. J. Duffin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 48 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 46 to December 25 48 and that I last saw him alive on 12/22/48

Immediate cause of death Myocardial Insufficiency DURATION 3 yrs

Due to Intermittent angina 3y

Due to Serbia ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Kustine H. Paucher, M.D. M. D. or other

Address Glen Burnie, Md. Date signed 12/25/48

RECEIVED

DEC 28 1948

BUREAU V. &

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12090

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel Co.
 City or town Eastport, near Annapolis, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 years
 Hospital, institution, or street address where death occurred:
611 Second Street
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel Co.
 City or town Eastport, near Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 611 Second Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____

3. (a) FULL NAME

Mary Elizabeth Brown

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Columbus C. Brown
 6.(c) If alive, give age 85 years
 7. Birth date of deceased (mo., day, yr.) June 27, 1876
 8. AGE: Years 72 Months 4 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business None
 12. Name Benjamin Brown
 13. Birthplace unknown
 14. Maiden name unknown
 15. Birthplace Florence Scott

16. Informant 354 W. Biddle St. Balto.; Md.
 Address
 17. Burial Date thereof 12-8-1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
St. Auburn
 Cemetery or crematory
West Port, near Baltimore, Md.
 Location

18. Funeral director Mrs. Charles E. Hicks
 Address 43-45 Northwest Street

19. Dec. 8, 1948
 (Date rec'd by registrar) Registrar M. J. French

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1948 at 4 25 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16 1948 to Dec 4 1948
 and that I last saw him alive on Dec 4 1948

Immediate cause of death Congestive Heart Failure DURATION _____
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury _____ Injured at work?

23. SIGNATURE M. J. French M. D. or other 10 Quail
 Address _____ Date signed 12-7-48

RECEIVED

DEC 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 mos., 25 days
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 9 mos 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1707 Edmundson Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war ***** ✓

3. (a) FULL NAME

CHARLES BUTLER

3. (b) Social Security Number

4. Sex MALE 5. Color or race colored 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Carrie Butler
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 19, 1897
 8. AGE: Years 51 Months 11 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore
 (Town, county, and state)
/ Chauffeur
 10. Usual occupation _____
 11. Industry or business none
 12. Name Charles Butler
 13. Birthplace Baltimore, Md.
 14. Maiden name Harriette Anne Butler
 15. Birthplace Baltimore, Md.

16. Informant Hospital Records
 Address Crownsville, Md.
 17. burial Date thereof Dec 31, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt Auburn
 Location Baltimore City Md
 18. Funeral director Mrs. Samuel J. Hensley
 Address 578 - W. Biddle St
 19. 12/28/48 E. J. Joyce, Sec
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/48 19 48 at 5:25 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/2/48 19 _____ to 12/27/48 19 _____
 and that I last saw him alive on 12/27/48 19 _____
 Immediate cause of death General Paresis

DURATION
 known to
 us
 since
4/2/48
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE James H. Hensley M.D.
 Address _____ Date signed _____

RECEIVED

DEC 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH:

County Anne Arundel County
City or town RURAL DORSEY MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

3. (a) FULL NAME

George William Cavey

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Frances M. Cavey

7. Birth date of

deceased (mo., day, yr.)

April 8 18736. (c) If alive, give age 69 years

8. AGE:

Years

Months

Days

If less than one day

7589

hrs.

min.

9. Birthplace

Howard Co. Maryland
(Town, county, and state)

10. Usual occupation

Stone Cutter (retired)

11. Industry or business

FATHER

12. Name

Ezekial A. Cavey

13. Birthplace

Maryland

MOTHER

14. Maiden name

Rebecca Tacey

15. Birthplace

West Virginia

16. Informant

Frances M. Cavey

Address

Race Road Dorsey Maryland

17.

Burial
(Burial, cremation, or removal, which?)

Date thereof

12-20-48
(month) (day) (year)

Cemetery or crematory

Mt. Oliver - Randallstown

Location

Randallstown, Md.

18. Funeral director

Wm. J. Tickner & Son

Address

Balto., Md.

19.

Dec 20 19 48
(Date rec'd by registrar)A. W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Rural Dorsey Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. Race Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 1719 48at 12:15 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 119 48to Dec 1719 48

and that I last saw him alive on

Dec. 1619 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

17 days

Due to

Cardio-Vascular Disease2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James S. Bellinger, M.D.

M. D. or other

Address

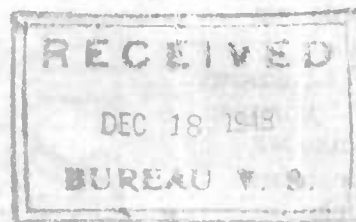
2200 Burnside, Md.Date signed Dec 18, 1948

MARGIN RESERVED FOR BINDING

VS-A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1881
60
1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Anne Arundel
 City or town Fort George G. Meade, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Months
 Hospital, institution, or street address where death occurred:
Station Hospital Ft Geo G. Meade, Md.
 How long in hospital or institution? 25 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Conn County Fairfield
 City or town Danbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 75 Garfield Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War #2 ✓

3. (a) FULL NAME

CHARLES AUGUSTUS DEAKIN

3. (b) Social Security Number

* *

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Deakin

6. (c) If alive, give age Unk years

7. Birth date of deceased (mo., day, yr.)

1 September 1922

8. AGE:

Years

26

Months

3

Days

17

It less than one day

hrs.

min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

Soldier US Army

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mary Deakin

Address

Ft Geo G. Meade, Md.

17.

(Burial, cremation, or removal. Which?)

Removal

Date thereof

Dec 18 48

(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Danbury, Conn

18. Funeral director

Lilly & Zeiler Inc

Address

1901-1907 Eastern Ave, Balto, Md.

19.

(Date rec'd by registrar)

22 Dec 48

48

JAMES N. GOERGER, CAPT.

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 December 19 48 at 1300 hrs21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 December 19 48 to 18 December 19 48 and that I last saw him alive on 18 December 19 48Immediate cause of death Severe brain damage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Subdural hematoma, right.Date of op. 17 Dec 48

Autopsy results

Pending

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 17 Dec 48Where did injury occur? Ft Meade A.A. MD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Army PostMeans of injury Grenade explosion Injured at work? Yes

23. SIGNATURE

Allen G. Thomas

ALLEN G. THOMAS, CAPT., M. D. or other MC

Address FT G G MEADE MDDate signed 22 Dec 48

ALSO ATTACHED

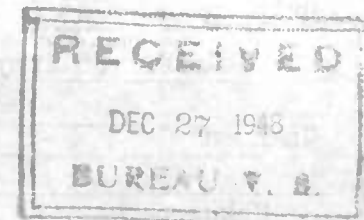
DATE OF DEATH

PLACE OF DEATH

STATIONER'S NO. 100-1000

DATE OF DEATH

CHARGE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Glen Burnie
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Glen Burnie
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7 Secone Ave. S.W.
 (If rural, give LOCATION)
 2(a) If veteran, name war none

3. (a) FULL NAME

HARRY T. DONALDSON

3. (b) Social Security Number

213 01 9462-A

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Bertha A. Donaldson
Nee Shuele 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) June 28, 1875
 8. AGE: Years 73 Months 5 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Anne Arundel County, Md.
 (Town, county, and state)
 10. Usual occupation Contractor (Retired)
 11. Industry or business Construction

12. Name Robert Donaldson
 13. Birthplace Anne Arundel County, Md.
 14. Maiden name Elizabeth J. Davis
 15. Birthplace Anne Arundel County, Md.

16. Informant Mrs. Bertha A. Donaldson
 Address 7 Second Ave. S.W. Glen Burnie, Md.

17. Burial Date thereof Dec. 17, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Glen Haven
 Location Glen Burnie, Md.

18. Funeral director Thomas W. Singleton
 Address Glen Burnie, Md.

19. 12/13 1948 [Signature]
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1948 at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1946 to Dec 13 1948
 and that I last saw him alive on Dec. 13 1948

Immediate cause of death Coronary Thrombosis
 DURATION 1 hour

Due to Coronary Vascular Disease 3 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE James S. Beal M.D. or other [Signature]
 Address Glen Burnie Md Date signed Dec 13 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF THE ARMY

HEADQUARTERS, ARMY AIR FORCE

OFFICE OF THE CHIEF OF STAFF

WASHINGTON, D. C.

MEMORANDUM FOR THE RECORD

RECEIVED

DEC 17 1948

BUREAU V. B.

Reg. Dist. No. 28

1. PLACE OF DEATH:

County..... Anne Arundel County
City or town..... Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years, 7 mos. 2 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 14 years, 7 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Millersville
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war ***

3. (a) FULL NAME

BESSIE DORSEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced	
Female	colored	married	
B.(b) Name of husband or wife <u>Alfred Pendleton</u>			
		**	
7. Birth date of deceased (mo., day, yr.)		8.(c) If alive, give age _____ years	
<u>ABT. 1907</u>			
8. AGE:	Years	Months	Days
	46	?	?
		If less than one day	
		** hrs. ** min.	

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1948 fs. 48 al. 5:00AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 1934 fs. 34 to Dec. 1 fs. 48 and that I last saw her er alive on Dec. 1, 1948 fs. 48

Immediate cause of death Exhaustion

DURATION

9. Birthplace.....	Maryland (Town, county, and state)
10. Usual occupation.....	Farmwork
11. Industry or business.....	none
MOTHER	
f2. Name.....	Nick Dorsey
13. Birthplace.....	Maryland
14. Maiden name.....	Susie Anna Queen
15. Birthplace.....	Maryland

Immediate cause of death.....	DURATION
.....
Due to.....
.....
Due to.....
.....
Other conditions	

Dementia Praecox

Hospital Records

18. Informant.....
Address Crownsville State Hospital

17. burial..... Date thereof 12 7 48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Mount Taber
Location Chestfield, Md.

18. Funeral director William Reese, II
Address 108 Washington St., Annapolis, Md.

19. December 3, 1948 E. J. [Signature] Registrar
(Date rec'd by registrar)

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results *****

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. ***** Date of ***

Where did injury occur? *****

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. D. or other

Crownsville State Hospital 12/1/48

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Anne ArundelCity or town Parole, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Turner Dorsey4. Sex male5. Color or race negro6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) November 30, 19058. AGE: Years 43 Months 0 Days 0 It less than one day 0 hrs. 0 min.9. Birthplace Parole, Md.
(Town, county, and state)10. Usual occupation Labor

11. Industry or business

12. Name Nick Dorsey13. Birthplace Maryland14. Maiden name Lucie Anne Queen15. Birthplace Maryland16. Informant Mrs. Skirah BradfordAddress Parole, Md.17. Burial 1-3-49
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)Cemetery or crematory Mt. TaborLocation Chesterfield, Md.18. Funeral director William Reese, Jr.Address 108 Washington St. Annapolis, Md.19. Jan. 3 1949
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Parole, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 0
(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1948 at 1:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1948 to Dec 31 1948and that I last saw him alive on Dec 30 1948Immediate cause of death Hypertensive Cardio-vascular disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Allen M. D. or otherAddress 10 Carroll Date signed Jan 3, 1949

RECEIVED

JAN 4 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b
33212098
22

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Q.A. Co
 City or town..... near Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 4 1/2 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel
 City or town..... Laurel, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Antonie Dreyer

3. (b) Social Security Number

4. Sex..... 7 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... M.
 6.(b) Name of husband or wife..... Chimise Dreyer
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... December 20, 1871
 8. AGE: Years..... 76 Months..... 11 Days..... 14 It less than one day..... hrs. min.

9. Birthplace..... Germany
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business..... Home
 12. Name..... Helmbrecht
 13. Birthplace..... Germany
 14. Maiden name.....
 15. Birthplace.....

16. Informant..... Adolph Dreyer
 Address..... S. Rolling Road, Catonsville, Md
 17. Burial Date thereof..... December 7, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Fort Lincoln
 Location..... District Line Rd
 18. Funeral director..... Dr. W. H. Donaldson
 Address..... Laurel, Maryland
 19. Dec 7 19 48 Blara Kasler
 (Date rec'd by registrar) Registrar

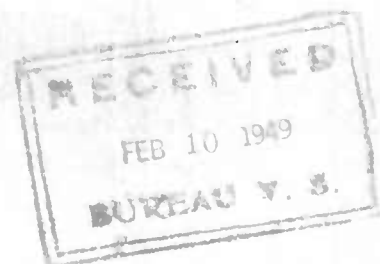
MEDICAL CERTIFICATION

20. DATE OF DEATH..... 12/4 19..... 48 at 20 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12/2 19..... 48 to..... 12/4 19..... 48
 and that I last saw her alive on..... 12/2 19..... 48

Immediate cause of death..... Cerebral Embolism DURATION..... 2
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accidental, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... W. B. Smith M. D. or other
 Address..... Laurel Date signed..... 1/6/49



PLEASE PRINT PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12099 20

1. PLACE OF DEATH:

County Anne ArundelCity or town Owensville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Maryland County Anne ArundelCity or town Owensville
(If outside city or town limits, write RURAL and give nearest town)Street No. RFD

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Benjamin Duvall Jr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Irene Duvall

7. Birth date of

deceased (mo., day, yr.)

Apr. 13, 18936. (c) If alive, give age 55 years

8. AGE:

55 Years7 Months22 Days

If less than one day

hrs.

min.

9. Birthplace

Owensville, A.A. County, Maryland
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Farming

MOTHER FATHER

12. Name

Benjamin Duvall Jr.

13. Birthplace

A.A. County, Maryland

14. Maiden name

Isabel Duvall

15. Birthplace

A.A. County, Maryland

16. Informant

Irene Duvall

Address

West River, Maryland

17.

Burial
(Burial, cremation, or removal, which?)Date thereof Dec. 10, 1948
(month) (day) (year)

Cemetery or crematory

David Star Line

Location

West River, Md.

18. Funeral director

W. H. Harty, Jr.

Address

Salisbury, Md.

19.

12/8
(Date rec'd by registrar)19. 48W. M. Clayton
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 5, 1948, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Postmortem Examinationand that I last saw it alive on Dec. 5, 1948

Immediate cause of death

Carcinoma of Stomach

DURATION

7 mos. or more

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address Annapolis, Md. Date signed 12-5-48

RECEIVED

DEC 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *28*

1. PLACE OF DEATH:

County Anne Arundel CountyCity or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs 16 daysHospital, institution, or street address where death occurred:
Crownsville State HospitalHow long in hospital or institution? 3 yrs 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1906 Lauretta Avenue
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

ETHEL RAY EDEMY

3. (b) Social Security Number

4. Sex F 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Unknown6. (c) If alive, give age dead years7. Birth date of deceased (mo., day, yr.) 18968. AGE: Years 52? Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housework

11. Industry or business _____

12. Name Joseph T. Ray13. Birthplace Maryland14. Maiden name Unknown15. Birthplace Unknown16. Informant Hospital RecordsAddress Crownsville, Maryland17. Burial Date thereof Dec 7 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory mt CalvaryLocation Brooklyn Md18. Funeral director Brooks & JuggoldAddress 1463 N. Carey St19. Dec 4 1948 E. F. Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1948 at 2:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1945, to December 3, 1948
and that I last saw er alive on December 3, 1948Immediate cause of death Catatonic Exhaustion
Known to us since DURATION 11/17/48

Due to _____

Due to _____

Other conditions Involuntional Psychosis
Known to us since 11/17/45
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David H. Hester M.D. M. D. or other _____Address Crownsville, Maryland Date signed 12/3/48

RECEIVED

DEC 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County A. A.City or town Jessups
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? four (4) weeks

Hospital, institution, or street address where death occurred:

Maryland House of CorrectionHow long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Ann ArundelCity or town Jessups
(If outside city or town limits, write RURAL and give nearest town)Street No. Maryland House of Correction
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

James A. Fearson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Nov. 17, 1884

8. AGE: Years Months Days If less than one day

64119

hrs. min.

9. Birthplace Centerville, Md.
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Maryland House Correction,recordAddress Jessups, Md.17. BURIAL Date thereof 1-4-49
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CHESTERFIELDLocation CENTERVILLE, MD18. Funeral director JOHN T. STANSBURYAddress 2700 EDMONDSON AVE.19. 20021 19 48 Elaine Headup

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1948 at 4:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 7, 1948, to Dec. 31, 1948and that I last saw him alive on Dec. 30, 1948Immediate cause of death Congestive heart failureDURATION 4 weeksDue to Mitral insufficiency

Due to.....

Other conditions Arterio-sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Clark M.D.

M. D. or other

Address MHC Jessups Md Date signed 12-31-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948-12-31
64-1-19
1884-11-12

RECEIVED
JAN 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 11/21/47

Hospital, Institution, or street address where death occurred.
Crownsville State Hospital

How long in hospital or Institution? 1 year 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State unknown County unknown

City or town unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown
(If rural, give LOCATION)

2.(a) If veteran, name war unknown

3. (a) FULL NAME

Lucy Garner (Gorman)

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife unknown
7. Birth date of deceased (mo., day, yr.) unknown 8. (c) If alive, give age unknown years

7. Birth date of deceased (mo., day, yr.) unknown ABT. 1888
8. AGE: Years 60 (?) Months ? Days ? If less than one day hrs. min.

9. Birthplace unknown
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business unknown

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Hospital Records

Address Crownsville, Maryland

17. buried Date thereof 12/22/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Crownsville

Location Aspen Hill

18. Funeral director Supr. Hosp. Bldg.

Address Crownsville, Md.

19. 12/22/48 87 Joyce L.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/48 19 48 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/21/47 19 48 to 12/17/48 19 48

and that I last saw her er alive on 12/17/48 19 48

Immediate cause of death General Paresis

DURATION

known to us since 11/21/47

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations: -----

Date of op. -----

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of -----

Where did injury occur? -----
(City or town) (County) (State)

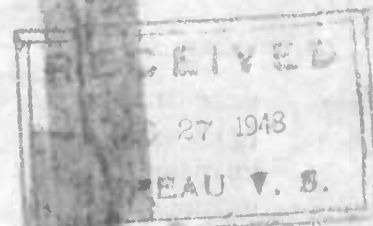
Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Jacob Margerison M.D.
M. D. or other

Address Crownsville, Maryland Date signed 12/17/48

1948
888
60



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH:

County ANNE ARUNDELCity or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.Co.City or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored Widow

8. (b) Name of husband or wife

Joseph Gray

7. Birth date of deceased (mo., day, yr.)

Nov. 25, 1870

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

78

0

7

hrs.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name

Lim Jackson

13. Birthplace

Washington D.C.

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Elizabeth Jones

Address

Crownsville, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof Dec. 10, 1948
(month) (day) (year)

Cemetery or crematory

Waterbury

Location

Waterbury, Md.

18. Funeral director

J.B. Johnson

Address

Annapolis, Md.

19.

Dec 9 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 19 48 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 19 47 to Dec 6 19 48and that I last saw him alive on Nov 4 19 48

Immediate cause of death

Hypertensive & Arteriosclerotic
Heart Disease

DURATION

2 years

Due to

Generalized Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Edna G. Chumett M.D.
M. D. or other

Address

Campbells Md

Date signed

Dec 8, 48

RECEIVED

DEC 12 1948

BUREAU V. S.

RECEIVED

DEC 13 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Deale, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 67 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel
 City or town..... Deale, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... U.S.

3.(a) FULL NAME

James Morris Hardesty

3.(b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Agnus Hardesty
 7. Birth date of deceased (mo., day, yr.)..... June 1879 8.(c) If alive, give age..... 60 years
 8. AGE: Years..... 69 Months..... 6 Days..... — It less than one day..... hrs. min.

9. Birthplace..... Calverton County, Md.
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

12. Name..... James D. Hardesty
 13. Birthplace..... Calverton County
 14. Maiden name..... Sarah E. Hardesty
 15. Birthplace..... Calverton County

16. Informant..... Robert C. Hardesty
 Address..... Deale, Md.

17. Burial Date thereof..... Dec. 31, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Deale Cemetery
 Location..... Deale, Md.

18. Funeral director..... Harvey Hutchinson
 Address..... Quincy - Md.

19. 129 1948 W. D. Clay
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 28, 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10th 1947, to Dec. 28 1948
 and that I last saw him alive on December 26 1948

Immediate cause of death..... Cerebral thrombosis

Due to..... arteriosclerosis - cerebral
& general

Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results..... no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... no Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

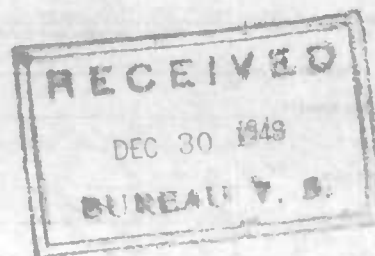
23. SIGNATURE..... Emil H. Wilson, M.D.
 Address..... Crofton, Md. Date signed..... 12-29-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948-12-28
69-6
1879-6



1948-12-28
69-6
1879-6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Ad. County
 City or town Box 156 Light St Rd
 (If outside city or town limits, write RURAL and give nearest town)
Glen Burnie
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Ad Co
 City or town Glen Burnie
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Box 156 Light St Rd
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lillie May Harding

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife George Harding 6. (c) If alive, give age 73 years
 7. Birth date of deceased (mo., day, yr.) April 7, 1878
 8. AGE: Years 70 Months 8 Days 22 If less than one day
 hrs. min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name Charles W. Ruby13. Birthplace Ind14. Maiden name Georganna Tracey15. Birthplace Ind16. Informant Mr George HardingAddress Box 156 Light St Rd17. Burial Date thereof 1/1/49
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Glen HavenLocation Annapolis Blvd18. Funeral director John J. Wenny IncAddress 145 Light St19. Dec. 31 19 48 LA-W. Heinrich
(Date rec'd by registrar) A.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29th 1948 at 3²⁰ A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
MAY 19 46 to DECEMBER 19 48and that I last saw her alive on DEC. 28 19 48Immediate cause of death GENERALIZED
CARCINOMA OF THE

DURATION

Due to CARCINOMA OF BREASTSDue to UNKNOWNOther conditions HYPERTENSION, EDENTAL

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE LF Zangara MD M. D. or otherAddress Glen Burnie Date signed 1/2/49

Mr Zangari
201 Baltimore
Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rachel Harris

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mathaniel Harris

7. Birth date of deceased (mo., day, yr.)

Feb. 13, 1887

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

61918

hrs.

min.

9. Birthplace

Mt. Zion, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Allen Diggs

13. Birthplace

Mt. Zion, Md.

14. Maiden name

Josephine Diggs

15. Birthplace

Mt. Zion, Md.

16. Informant

Sidney Davis

Address

1115 Chapel St. Norfolk Va.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

12 22 48
(month) (day) (year)

Cemetery or crematory

Salesville

Location

Salesville Md.

18. Funeral director

William Reese, Jr.

Address

108 Washington St. - Annapolis, Md.

19.

12/22 48
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 Calvert Court
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948, at 48 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17, 1948, to Dec. 19, 1948and that I last saw him er alive on December 19, 1948Immediate cause of death Hypertensive Cardiovascular Disease

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

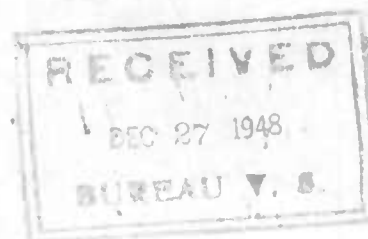
23. SIGNATURE

Herbert H. Johnson, Jr.

M. D. or other

Address

40 Northampton St.Date signed 12/24/48



grave and service
11 a.m.

grave . . . \$12.00

RECEIVED
DEC 13 1948
BUREAU A. G.

1948-12-8
11-11

627-50

1889-7-19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne ArundelCity or town Gambrell
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.City or town Gambrell
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Johnson

3. (b) Social Security Number

4. Sex Male5. Color or race Colored6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Unknown abt. 18688. AGE: Years 80 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace St. Marys Co. Md.
(Town, county, and state)10. Usual occupation Farmer hand11. Industry or business Farming12. Name Unknown

13. Birthplace _____

14. Maiden name Unknown

15. Birthplace _____

16. Informant Bernard HardistyAddress Salisbury Md.17. Burial Date thereof 12/17/48
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetary or crematory ChewsLocation Owensville Md.18. Funeral director T.A. Hardisty & SonAddress Salisbury Md.19. Dec. 17 19 48 E. J. Joyce Doc
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 19 48 at 3 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from only December 15 19 48and that I last saw him alive on December 15 19 48

Immediate cause of death _____ DURATION

Acute Myocardial 3 daysDue to Arterio-sclerosis 2 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

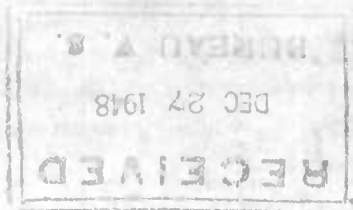
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Richardson M. D. or otherAddress 118 - Gay St. Salisbury Md. Date signed 12/18/48

Charles H. Masters

1921 - 1948



8981
—
88
1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12109 21

1. PLACE OF DEATH

County Cyrc Anne delCity or town Serem
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Kim Johnson

4. Sex

M

5. Color or race

B

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

January 25, 1960.

8. AGE:

Years

Months

Days

If less than one day

88

hrs. min.

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Dec 13, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants, give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2. (a) If veteran, name war

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2. (a) If veteran, name war

2. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 15, 1948

and that I last saw him alive on

Dec 1, 1948

Immediate cause of death

Acute coronary thrombosis

Due to

Due to

Other condition

Cardiovascular Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

CERTIFICATE OF DEATH

Registered No. 12110-21

1. PLACE OF DEATH *Angie Arundel Co.*
 (a) *Baltimore City, Maryland*
 (b) Street address *Jessups Md.*
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED *Angie Arundel Co.*
 (a) State *Md.* (b) County *Jessups*
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME *Maggie Johnson*
 3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex *Female* 5. Color or race *Col.* 6 (a) Single, married, widowed, or divorced *Widow*
 6 (b) Name of husband or wife *Benjamin*
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug 11, 1886*
 8. AGE: Years *62* Months _____ Days _____ If less than one day
 hr. _____ min. _____

9. Birthplace *Na*
 (Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

FATHER 12. Name *Harold Persons*
 13. Birthplace *Na.*

MOTHER 14. Maiden Name *Eliya ?*
 15. Birthplace *Na.*

16 (a) Informant *Lillie Mc Clain*
 (b) Address *Jessups Md.*

17 (a) *Burial* (b) Date thereof *12 16 48*
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory *Mt Calvary Cem.*
 Location *A. A. County Md.*

18 (a) Funeral director *Mrs. G. F. Ellis & Dgt.*
 (b) Address *1129 N. Caroline St.*

19 (a) *12/14/48* (b) *J. P. Hedrick*
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 12 1948* at *8:45 PM*
 21. I certify that death occurred on the date above stated that I attend
 ed deceased from *Nov 11 1948* to *Dec 12 1948*
 and that I last saw him alive on *Dec 5 1948*

Immediate cause of death *Bone Infection*
 Due to *Tubercular Infection* Duration *6 yrs*

Due to:
 Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *John W. Hedrick*

Address *Elkridge Md* Date signed *12-14-48*

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124a

12111

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Prince Georges
 City or town Annapolis Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3 days

3. (a) FULL NAME

John Preston Jones

3. (b) Social Security Number

4. Sex

m

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of (A. APPROX.)
deceased (mo., day, yr.)Jan 6 - 1909

6. (c) If alive, give age years

8. AGE

Years

Months

Days

If less than one day

40

hrs. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

MOTHER

12. Name

John Jones

13. Birthplace

Md

14. Maiden name

Fannie E. Chance

15. Birthplace

Md

16. Informant

Wife

Address

Wife

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec 23 - 48
(month) (day) (year)

Cemetery or crematory

Church Hill

Location

Church Hill Md

18. Funeral director

Address

Edgar J. Lane

19.

(Date rec'd by registrar)

19.

W. J. Branch
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 19 48 at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 18 19 48 to Dec 20 19 48and that I last saw him alive on Dec. 19 19 48

Immediate cause of death

DURATION

Cirrhosis of liver

Due to

Alcoholism

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. F. Klawans, MD

M. D. or other

Address

315 Mt. Airy Ave Date signed 12/20/48

9311-4

RECEIVED
DEC 21 1913
BUREAU OF S.

44-1-11
Chief Clerk
Chief Clerk
Chief Clerk
Chief Clerk
Chief Clerk

EVIDENCE FOR CHANGE
OF BIRTH DATE SHOWN ON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE No. G 118 DEC 29 1948

CERTIFICATE OF DEATH

12112 26
Reg. Dist. No.

1. PLACE OF DEATH:

County *aa*

City or town *Deale*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *AA*

City or town *Deale*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Mary E. Leatherbury

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *W*

6. (b) Name of husband or wife *Wm Leatherbury*

7. Date of death *March 23, 1869*
(mo., day, yr.)

8. AGE: Years *79* Months *8* Days *15*
If less than one day _____ hrs. _____ min.

9. Birthplace *MD*
(Town, county, and state)

10. Usual occupation *Domestic*

11. Industry or business *Robert Insurance*

12. Name *MD*

13. Birthplace *MD*

14. Maiden name *Ellen Stallings*

15. Birthplace *Deale*

16. Informant *Mrs Clarence Love*

Address *Deale*

17. *Burial* Date thereof *Dec 11, 1948*
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory *Traverse*

Location *MD*

18. Funeral director *H. A. Hargis & Son*

Address *Deale*

19. *Dec 11, 1948* *J. B. Dent*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *12/8* 19*48* at *11:45* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec 1* 19*48* to *Dec 8* 19*48*

and that I last saw him alive on *Dec 8, 1948*

Immediate cause of death *arteriosclerosis*

DURATION

5 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *H. A. Hargis & Son*

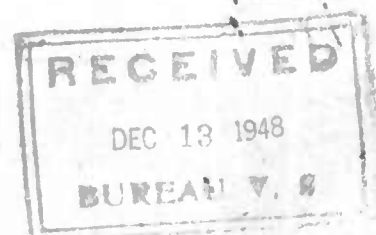
M. D. or other

Address *Deale* Date signed *12/19/48*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, institution, or street address where death occurred:
South River Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Parole (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Annapolis, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES FRANKLIN LEWIS

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Eliza H. Lewis
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) December 17, 1856
8. AGE: Years 92 Months 0 Days 8 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Farmer + Chief Deputy Sheriff
11. Industry or business

FATHER 12. Name Louis Lewis
13. Birthplace Maryland
MOTHER 14. Maiden name Emily Carrick
15. Birthplace Maryland

16. Informant Mrs Bessie B. Brashears
Address Parole, Nr Annapolis, Maryland
17. Burial Date thereof 12-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Anne's Cemetery
Annapolis, Maryland
Location
18. Funeral director Ben L. Hopping and Son
Address 170-172 West St. Annapolis, Maryland

19. Dec 28, 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1948 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 1948 to Dec 25, 1948
and that I last saw him alive on Dec 24, 1948

Immediate cause of death Myocardial infarction
DURATION years

Due to Coronary
Other conditions years
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

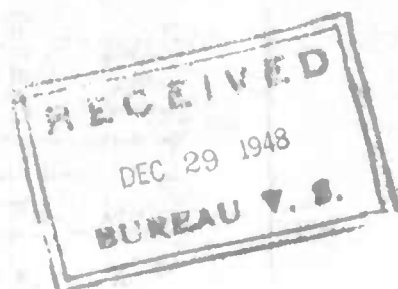
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George B. Brail
M. D. or other
Address Annapolis, Md Date signed 12-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

.....hrs.

.....min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 48

19. 48

19. 48

19. 48

19. 48

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19. 48

19. 48

19. 48

19. 48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED
FEB 10 1949
TREASURY V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12115 28

1. PLACE OF DEATH:

County Anne Arundel
City or town Herold Harbor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo 27 days
Hospital, institution, or street address where death occurred:
Holly Trail
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Herold Harbor (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Crownsville Post Office
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Donald Frank Matchett

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 4, 1948

8. AGE: Years 0 Months 1 Days 27 If less than one day hrs. min.

9. Birthplace Annapolis, Anne Arundel, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Frank W. Matchett
13. Birthplace Washington, D.C.

14. Maiden name Ella McKenzie
15. Birthplace Washington, D.C.

16. Informant Mr. Frank W. Matchett (Father)

Address Holly Trail Herold Harbor, Maryland
Crownsville Post Office, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof 1-31-49 (month) (day) (year)

Cemetery or crematory Baldwin Memorial Cemetery
Location Millersville, Maryland

18. Funeral director Ben L. Hopping and Son
Address 170-172 West St. Annapolis, Maryland

19. Jan 3 19 49 E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31, 1948 at about 2 P.M.

21. I CERTIFY that death occurred on the date Dec 31, 1948 at about 2 P.M.
that I attended deceased from Postmortem Examination
and that I feel sure he Dec 31, 1948

Immediate cause of death Suffocation DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 12-31-48

Where did injury occur? Herold Harbor A.A. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Suffocation Injured at work?

23. SIGNATURE John M. Slaff, M.D. Sept 12-31-48
Anne Arundel M. D. or other Examiner

Address 12-31-48 Date signed

MARGIN RESERVED FOR BINDING

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 6 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

12116

1. PLACE OF DEATH:

County Anne Arundel
 City or town Severna Park
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Severna Park
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

William E. McRay

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Louise Miller McRay

7. Birth date of

July 4th 1879

6.(c) If alive, give age. years

8. AGE:

Years

Months

Days

If less than one day

69429

hrs

min.

9. Birthplace

Front Royal Va
(Town, county, and state)

10. Usual occupation

Ret. Pres. of Wm E McRay

11. Industry or business

Cotton Food Co.

FATHER

12. Name

Alfred G. McRay

13. Birthplace

Va

MOTHER

14. Maiden name

Amy E. McRay

15. Birthplace

Va

16. Informant

Antonium G. McRay

Address

Severna Park Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

Dec 6th 1948
(month) (day) (year)

Cemetery or crematory

Wm. Nebron

Location

Winchester Va

18. Funeral director

John M. Taylor Son

Address

Annapolis Md.

19. Dec 3 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

12/2/4819 48

at

6

P

M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept.19 48

to

12/2/4819 48

and that I last saw him alive on

12-2-4819 48

Immediate cause of death

Broncho pneumonia

DURATION

3 days

Due to

Cerebral Hemorrhage6 yrs.

Due to

with Art. HemiplegiaCardio-Vascularrenal disease7 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James R. Martin, Jr. M.D.

M. D. or other

Address

Annapolis, Md.

Date signed

12/3/48

RECEIVED

DEC 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Severna
 City or town Severna, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AN Ar
 City or town SEVERNA
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

John Stanley Oliver

3. (b) Social Security Number

4. Sex M. 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Rosie Lambrell
 6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec. 13 - 1884
 8. AGE: Years 64 Months 0 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Peermaw

11. Industry or business

FATHER 12. Name Stanley Oliver
 13. Birthplace a-a. county, Md.
 MOTHER 14. Maiden name Mary Butler
 15. Birthplace Baltimore, Md.

16. Informant Mary Marshall (daughter)
 Address Severna, Md.

17. Burial Date thereof Dec. 26 - 48
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Quiver, Private
 Location a-a. Co. - Md.

18. Funeral director James A. Stanger
 Address 142 W. Hill St.

19. 12-23-48 a.w. Haskins
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1948 at 6:40 P.M.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____.

Immediate cause of death Coronary
Obstruction DURATION sudden

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert P. Pouchard, M.D.
 Address 142 W. Hill St. Date signed 12/21/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne ArundelCity or town Lothian
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.City or town Lothian
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bessie Parker

3. (b) Social Security Number

4. Sex

F.

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George Parker

7. Birth date of deceased (mo., day, yr.)

Nov. 9. 1903

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

4611

hrs.

min.

9. Birthplace

Starwood

(Town, county, and state)

10. Usual occupation

Home

11. Industry or business

MOTHER FATHER

12. Name

Charles Moreland

13. Birthplace

Lothian

14. Maiden name

Alveta Brown

15. Birthplace

Lothian

16. Informant

Address

17.

(Burial, cremation, or removal? Which?)

Date thereof Dec. 13, 1948
(month) (day) (year)

Cemetery or crematory

Gr. Jim Lee

Location

Lothian, Md.

18. Funeral director

Address

19.

(Date rec'd by registrar)

12/13/4815W. H. Clayton

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1948 at 6:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 10 1948 to Dec 10 1948and that I last saw him alive on Dec 10 1948

Immediate cause of death

cerebral hemorrhage

Due to

hypertension

Due to

arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Clayton, M.D.

M. D. or other

Address

Lothian, Md.Date signed 12/13/48

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12118

20

RECEIVED

DEC 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12119

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Arnold
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Helen E. Phipps

7. Birth date of deceased (mo., day, yr.) July 11th 1896 6. (c) If alive, give age _____ years

8. AGE: Years 52 Months 9 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace A. G. Co. Md.
 (Town, county, and state)

10. Usual occupation Auto mechanic

11. Industry or business

12. Name Jefferson Phipps13. Birthplace A. G. Co. Md.14. Maiden name Adderene Owens15. Birthplace A. G. Co. Md.16. Informant Helen E. PhippsAddress Arnold P.O. A. G. Co. Md.

17. Burial Date thereof Dec 9th 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Ashbury CemeteryLocation Arnold Md.18. Funeral director John M. Taylor SonAddress Annapolis Md.

19. Dec 9 19 48
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Arnold P.O.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 19 48 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 19 46 to December 6 19 48
 and that I last saw him alive on October 15 19 48

Immediate cause of death _____

DURATION

Ac. Coronary Occlusion 2 hrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. F. Klawans, M.D.

M. D. or Other

Address Annapolis Date signed md

Registrar

RECEIVED
DEC 10 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: County <u>Anne Arundel Co.</u> City or town <u>Annapolis</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>45 Years</u> Hospital, institution, or street address where death occurred: <u>76 Clay Street</u> How long in hospital or institution? _____		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Anne Arundel Co.</u> City or town <u>Annapolis</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>76 Clay Street</u> (If rural, give LOCATION) 2.(a) If veteran, name war _____	
3. (a) FULL NAME <u>Cathrine Pindell</u>		3. (b) Social Security Number _____	
4. Sex <u>Female</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
6. (b) Name of husband or wife <u>Charles Pindell</u>		6. (c) If alive, give age _____ years	
7. Birth date of deceased (mo., day, yr.) <u>August 27, 1867</u>			
8. AGE: Years <u>81</u>	Months <u>3</u>	Days <u>7</u>	It less than one day _____ hrs. _____ min.
9. Birthplace <u>Mt. Zion A.A.Co. Md.</u> (Town, county, and state)			
10. Usual occupation <u>Housewife</u>			
11. Industry or business <u>None</u>			
12. Name <u>Richard Owens</u>			
13. Birthplace <u>Mt. Zion A.A.Co. Md.</u>			
14. Maiden name <u>Priscilla Brown</u>			
15. Birthplace <u>Anne Arundel Co. Md.</u>			
16. Informant <u>Hattie Smith</u> Address <u>76 Clay Street Annapolis, Md.</u>			
17. Burial (Burial, cremation, or removal. Which?) Date thereof <u>12-7-1948</u> (month) (day) (year) Cemetery or crematory <u>Brewer Hill</u> Location <u>West Street Extended</u>			
18. Funeral director <u>Mrs. Charles E. Hicks</u> Address <u>43-45 Northwest Street</u>			
19. December 6, 1948 (Date rec'd by registrar)			
20. DATE OF DEATH <u>4 December 1948</u> at <u>3:15 PM</u>			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 15</u> 19 <u>48</u> to <u>Dec 4th</u> 19 <u>48</u> and that I last saw her alive on <u>Dec 4th</u> 19 <u>48</u>			
Immediate cause of death <u>Coro Vascular Failure</u>		DURATION <u>Several months</u>	
Due to <u>Arteriosclerosis</u>		<u>years</u>	
Due to <u>Arteriosclerosis</u>		<u>years</u>	
Other conditions _____ (Include pregnancy within 8 months of death)			
Major findings of operations _____ Date of op. _____			
Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
23. SIGNATURE <u>John P. Parris</u> M. D. or other _____ Address <u>Annapolis Md</u> Date signed <u>12/6/48</u>			

Registrar

RECEIVED

DEC 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

12121

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.
 County.....
 City or town..... Arnold, Md. near Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 Arnold, Md. near Annapolis
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Anne Arundel
 City or town..... Arnold, Md. near Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Arnold, Md. near Annapolis
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 William A. Porter

3. (b) Social Security Number
 212- 14- 3196

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Hannah Porter
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) April 20, 1886
 8. AGE: Years Months Days If less than one day
 62 7 13hrs.min.

9. Birthplace St. Margrets, Anne Arundel Co. Md.
 (Town, county, and state)
 10. Usual occupation Laborer & Gardener
 11. Industry or business None

FATHER 12. Name James Porter
 13. Birthplace St. Margrest, Anne Arundel Co. Md.
 MOTHER 14. Maiden name Jenna Bonds
 15. Birthplace St. Margrets, Anne Arundel Co. Md.
 16. Informant Hannah Porter

Address Arnold Md. Anne Arundel Co. Md
 17. Burial Date thereof 12- 6-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Calvery Cemetery
 Location Arnold, Md. Anne Arundel Co. Md.

18. Funeral director Mrs. Charles E. Hicks
 Address 43-45 Northwest Street

19. Dec 6, 1948
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1948 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16, 1948 to December 3, 1948 and that I last saw him alive on Dec 3, 1948

Immediate cause of death Cerebral Hemorrhage DURATION 2 weeks

Due to Arterial Hypertension 1 year

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE P. L. Rabinovich M. D. or other
 Address 150 - E. St. Annapolis, Md. Date signed 12/5/48

RECEIVED

DEC 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12122

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 79 Conduit
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Cora E Prather

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Columb M Prather

7. Birth date of

deceased (mo., day, yr.)

July 6th 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

86519

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name

Charles H. Stevens

13. Birthplace

Maryland

14. Maiden name

Malisa A. Jones

15. Birthplace

Maryland

16. Informant

Julia F. Stevens

Address

79 Conduit St. Annapolis Md.

17. Burial

(Burial, cremation, or other)

Date thereof

Dec 27th 1948
(month) (day) (year)

Cemetery or crematory

Cedar Bluff

Location

Annapolis Md.

18. Funeral director

John M. Taylor, Son

Address

Annapolis Md.

19. Dec. 27 19 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 2519 48at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 2019 48to Dec 2519 48and that I last saw him alive on Dec 25 19 48

Immediate cause of death

Cardio Vascular Failure

Due to

Cancer of Pancreas

Due to

General Carcinomatosis

Other conditions

Severe infection

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

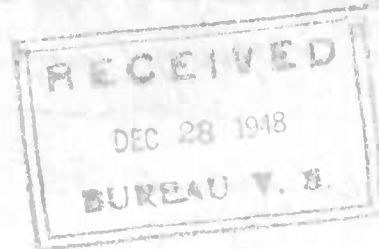
Injured at work?

23. SIGNATURE

Oliver Turner
Annapolis Md. Date signed Dec 26/48

M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel County
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Six months 15 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No. -----
(If rural, give LOCATION)
2. (a) If veteran, name war no

3. (a) FULL NAME

JACOB PRICE

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife unknown (deceased)
6. (c) If alive, give age ----- years
7. Birth date of deceased (mo., day, yr.) (unknown) A.B.T. 1859
8. AGE: Years 89 Months ---- Days ---- It less than one day ----- hrs. ----- min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation unknown
11. Industry or business -----
12. Name unknown
13. Birthplace unknown
14. Maiden name unknown
15. Birthplace unknown

16. Informant Hospital Records
Address Crownsville State Hospital

17. Burial Date thereof December 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mount Calvary
Location Arnold, Maryland

18. Funeral director J. B. Johnson
Address Annapolis, Maryland

19. Dec 5, 19 48 57004 Done
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 19 48 at 5:00 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1948 19 ----- to December 2, 19 48and that I last saw him alive on December 2, 1948 19 -----

Immediate cause of death
General Arteriosclerosis
known to us since 6/17/48

Due to Senile Psychosis
Due to Senile Marasm

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

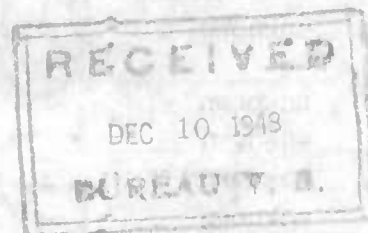
Accident, suicide, or homicide ----- Date of -----Where did injury occur? -----
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Jacob Price M. D. or otherAddress Crownsville, Maryland Date signed 12/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948
87
1859



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12124

Reg. Dist. No. 30d

1. PLACE OF DEATH:

County Anne Arundel
City or town Green Haven, (Pasadena, P.O.) Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Green Haven, (Pasadena, P.O.) Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5th. St. & East Shore Drive
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Paul W. Pumphrey

3. (b) Social Security Number

579-05-4307

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
6. (b) Name of husband or wife Elizabeth F. Pumphrey
Nee Alvey 6. (c) If alive, give age Deceased
7. Birth date of deceased (mo., day, yr.) January 15, 1881
8. AGE: Years 67 Months 11 Days 8 If less than one day
hrs. min.

9. Birthplace Washington, D.C.
(town, county, and state)
10. Usual occupation Painter (Retired)
Washington, D.C.
11. Industry or business Schreiber Decorating Co.
12. Name John Wesley Pumphrey
13. Birthplace Prince George County, Md.
14. Maiden name Mary Catherine Lewis
15. Birthplace Washington, D.C.

18. Informant Albert Plews
Address Green Haven, (Pasadena, P.O.) Md.
17. Burial Date thereof Dec. 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Glen Haven
Cemetery or crematory
Glen Burnie, Md.
Location
Thomas W. Singleton
18. Funeral director
Address Glen Burnie, Md.

19. 12/27 19 48
(Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1948 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1948 to Dec 20 1948
and that I last saw him alive on 12/20/48

Immediate cause of death
Pulmonary Hemorrhage & embolism
Due to Arteriosclerosis of aorta
Due to Arteriosclerosis of aorta + embolism
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

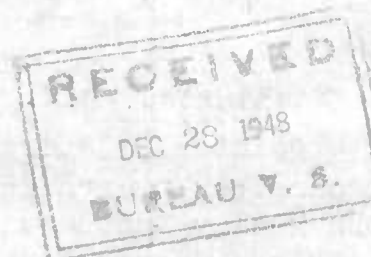
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Pendergast
M. D. or other
Address Glen Burnie, Md. Date signed 12/24/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Anne Arundel

Village or City Lenthum Hb (No.)

2 FULL NAME Henry K. Remover

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Jan. 6, 1882
(Month) (Day) (Year)

7 AGE 66 yrs. 10 mos. 16 ds. IF LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Motorman B & O R.R.
(b) General nature of industry business, or establishment in which employed or (employer) Retired

9 BIRTHPLACE (State or country) Baltimore, Md.

10 NAME OF FATHER John Remover

11 BIRTHPLACE OF FATHER (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sophia Imhof

13 BIRTHPLACE OF MOTHER (State or Country) Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Henry K. Remover. (wife)

(Address) 544 Forest View Rd. Lenthum Hb

15 Filed 12-6 1948 A. W. Hedrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 2, 1948
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 1945 to Dec 2, 1948, that I last saw him alive on Nov 30, 1948

and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH * was as follows:

Hemorrhage in the Brain.

Contributory
Secondary

Immediate
(Duration) ____ yrs. ____ mos. ____ ds.

Cerebro-Vascular Disease

(Signed) Jama S. Beall M. D.
Dec 8, 1948 (Address) Green Burner Rd.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meadowridge

12/6, 48

20 UNDERTAKER

ADDRESS

Leonard J. Luck

5305 Harford Rd.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12126

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Prince George's
 City or town Brooklyn Heights
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Not 20 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Brooklyn Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rm 500 Doris Dr.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Daniel B. Schnupfe

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

Nannie6. (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.)

Dec. 20, 1875

8. AGE:

Years

Months

Days

If less than one day

72

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Benjamin Schnupfe

13. Birthplace

Germany

MOTHER

14. Maiden name

Augusta Schnupfe

15. Birthplace

Germany

16. Informant

Mrs. Grace Schnupfe

Address

503 Pontiac Ave

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

12/20/48
(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Annapolis Blvd

18. Funeral director

John F. Kennedy Inc

Address

415 Light St

19. December 26 48

(Date rec'd by registrar)

A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 16, 1948, at 9:00 P.M.21. I CERTIFY that death occurred on the date above stated; autopsy performed

Postmortem Examination
~~at the place of death~~ Dec. 16, 1948

Immediate cause of death

DURATION

Due to

Bullet wound
in right temple

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 12-15-48

Where did injury occur? Brooklyn Heights A.D. Maryland
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

at homeMeans of injury 22 cal revolver

Injured at work?

23. SIGNATURE

John M. Coffey, M.D.
Annapolis Md
 M. D. or other Ex. Asst. Surgeon
 Date signed 12-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

12127

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 days
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution? 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Parole (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. nr Annapolis,
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

CHARLES W. SEARS

3. (b) Social Security Number

220-16-8676

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs Susie B. Sears
 7. Birth date of deceased (mo., day, yr.) June 10, 1872
 6. (c) If alive, give age 69 years
 8. AGE: Years 76 Months 6 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Calvert County, Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name William T. Sears

13. Birthplace Maryland

14. Maiden name Emma Childs

15. Birthplace Maryland

16. Informant Mr. Robert C. Sears (Son)

Address Gedar Park, A.A. Co., Maryland

17. Burial Date thereof 1-2-49
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Mt. Zion Methodist Cemetery

Location Mt. Zion, A.A. Co., Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis Maryland

19. Jan 2, 49
 (Date rec'd by registry) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1948 at 3:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1948 to Dec. 31, 1948
 and that I last saw him alive on Dec. 31, 1948
 Immediate cause of death Coronary occlusion

DURATION 2 1/2 days
 Due to arteriosclerosis
cardiovascular disease 8-10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE E. B. [Signature] M. D. or other

Address Annapolis Md Date signed 12/31/48

RECEIVED

JAN 4 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DATA

RECEIVED

DEC 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 932 12129

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Dead on arrival
 Hospital, institution, or street address where death occurred: Emergency Hospital
 How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 81 Pleasant
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Lottie Simms

3. (b) Social Security Number

4. Sex Female 5. Color or race negro 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife William Simms

7. Birth date of deceased (mo., day, yr.) August 29, 1888 6. (c) If alive, give age _____ years

8. AGE: Years 60 Months 8 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Edgewater, Md. A. A. Co
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Nelson Wells13. Birthplace A. A. Co. Md.14. Maiden name Patsie Wells15. Birthplace A. A. Co. Md.16. Informant George WellsAddress Annapolis, Md.17. Burial Date thereof Dec. 30, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hopes ChapelLocation Edgewater, Md.18. Funeral director J. B. JohnsonAddress Annapolis, Md. Box 46219. Dec. 29, 1948(Date rec'd by registrar) Registrar J. B. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1948 at 10:50 A.M.21. I CERTIFY that death occurred on the date above stated: Post mortem ExaminationDec. 27, 1948Immediate cause of death Acute Cardiac Dilatation DURATION suddenDue to Chronic myocarditis unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Coffey M.D. DeputyAddress Annapolis, Md. M. D. or other ExaminerDate signed 12-27-48

RECEIVED

DEC 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

12130

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Anne Arundel
 City or town Edgewater
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 3 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County C. G.
 City or town Edgewater
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hester Smith

3. (b) Social Security Number

✓

4. Sex female 5. Color or race negro 6.(a) Single, married, widowed, or divorced Widow
 8.(b) Name of husband or wife Unknown
 7. Birth date of deceased (mo., day, yr.) ABT. 1883 6.(c) If alive, give age _____ years
 8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Eastern shore Md
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business Unknown
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Barrie Green
 Address Edgewater Md

17. Burial Date thereof Dec 23, 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Hobbs Chapel
 Location Edgewater Md

18. Funeral director F. A. Audette
 Address Salisville Md

19. Dec 22 19 48 Edward Collier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 19 48 at 6 25 P. M.

21. I CERTIFY that death occurred on the date above stated; Postmortem Examination
Dec. 20, 1948

Immediate cause of death Acute Cardiac Failure DURATION Instant
 Due to General Arterio-sclerosis
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? Depot

23. SIGNATURE John M. Coffey M.D. Medical Examiner
Annapolis, Md. M. D. of other _____

Address _____ Date signed 12-20-48

RECEIVED

DEC 30 1948

BUREAU 7. 8.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County P. B.City or town Linthicum
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Lynman Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State P. B. County Prince George'sCity or town Pine
(If outside city or town limits, write RURAL and give nearest town)Street No. 100
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Washington Snowden

3. (b) Social Security Number

4. Sex

male

5. Color or race

col.

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Sophie Snowden6.(c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) May 17 18868. AGE: Years 62 Months 0 Days 0 If less than one day 0 hrs. 0 min.9. Birthplace A. A. Co. Md.
(Town, county, and state)10. Usual occupation Labourer

11. Industry or business

12. Name George - Snowden13. Birthplace (maiden name)14. Maiden name Mary Jane Snowden

15. Birthplace

16. Informant BurialAddress 12-19-4817. Burial Date thereof 12-19-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Inf. Green Cem.Location Brownlee, Md.18. Funeral director Elroy O. WilsonAddress 1000 Beantley Ave19. December 19 19 48
(Date rec'd by registrar) Registrar W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 19 48, at 5:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 19 47, to Dec. 16 19 48, and that I last saw him alive on Dec. 16 19 48Immediate cause of death Cardio-vascular Disease DURATION 18 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball M. D. or otherAddress Linthicum Date signed 12-16-48

MARGIN RESERVED FOR BINDING

VS-A15

9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

78
15
8431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12132

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County A.A.
 City or town Severna Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Robert I. Stewart

3. (b) Social Security Number

212-09-7958

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Cora Lee Stewart
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) April 5th 1895
 8. AGE: Years 53 Months 8 Days 28 It less than one day..... hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1948
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1943 to Dec 30 1948
 and that I last saw him alive on Dec. 30 1948
 Immediate cause of death uræmia
 Due to arteriosclerotic cardio-vascular renal disease
 Due to hypertension
 DURATION 3 days
 Other conditions.....
 (Include pregnancy within 3 months of death)

9. Birthplace Balto. Md.
 (Town, county, and state)
 10. Usual occupation Chief Engineer
 11. Industry or business Crown Rock Seal Co.
 12. Name Robert Stewart
 13. Birthplace Scotland
 14. Maiden name Florence George
 15. Birthplace England
 16. Informant Mrs. Cora Lee Stewart
 Address Severna Park A.A.Co. Md.
 17. Burial Burial Date thereof Jan 3rd 1949
 (Burial, cremation, or removal-Which?) (month) (day) (year)
 Cemetery or crematory London Park
 Location Balto. Md.
 18. Funeral director William Cook Inc.
 Address 127 St. Paul St.

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE S. Brunswick M.D.
 Address Annapolis Md Date signed 12/30/48
 19. Dec. 31 1948 A.A. Adrich
 (Date rec'd by registrar) a.s., Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

12133

Reg. Dist. No. 21

1. PLACE OF DEATH:

County 4 ap.
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 18 Hours
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County 2
 City or town Harwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Lydia H. Suttore

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Edward Suttore

7. Birth date of deceased (mo., day, yr.)

May 22 - 1875

6. (c) If alive, give age _____ years

8. AGE:

73

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

James Hardisty

13. Birthplace

Maryland

MOTHER

14. Maiden name

Eliza Beth Hardisty

15. Birthplace

Maryland

16. Informant

Cora H. Lee

Address

Harwood Maryland

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

Dec 8/48
(month) (day) (year)

Cemetery or crematory

Gravette Cemetery

Location

Galesville, Md

18. Funeral director

J. H. Heston & Sons

Address

1017 Harmony Road

19.

Dec 7 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 19 48 at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 19 48 to Dec 6 19 48 and that I last saw u alive on Dec 6 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

Sudden

Due to

Arterio SclerosisArterio Sclerosis

Due to

Myocarditis (Ch)Myocarditis

Other conditions

HypertensionHypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

George C. Bond

M. D. or other

Address

Annapolis MdDate signed 12-7-48

RECEIVED

DEC 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution street address where death occurred:

105 Prince George St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 105 Prince George St.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

George E. Taylor

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Sadie F. Taylor

7. Birth date of

deceased (mo., day, yr.)

January 21st 1887

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

61125

hrs.

min.

9. Birthplace

Annapolis, Md. D.C.

(Town, county, and state)

10. Usual occupation

Plumber

11. Industry or business

MOTHER

12. Name

William Henry Taylor

13. Birthplace

Maryland

14. Maiden name

Anna M. Thomas

15. Birthplace

Maryland

16. Informant

Mrs. Sadie F. Taylor

Address

105 Prince George St. Annapolis Md17. Burial

(Burial, cremation, or other. Which?)

Date thereof

12/19/48

Cemetery or crematorium

Sadar Bluff

Location

Annapolis Md.

18. Funeral director

John M. Taylor

Address

Annapolis, Maryland19. Dec 17 19 48

(Date rec'd by registrar)

Registrar

23. SIGNATURE

George E. Boil

M. D. or other

Address

Annapolis MdDate signed 12.16.48

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 48 at 10 a m

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 47 to Dec 16 48and that I last saw him alive on Dec 15 48

Immediate cause of death

Pulmonary Edema
Pulmonary Interstitial

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

MARGIN RESERVED FOR BINDING

VS A15

9-45-19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County St. A.
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

251 Hanover St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For infants give residence of mother)

State Ind. County St. A.

City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 251 Hanover St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Martha Ellen Thomas

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife

Edward Thomas

7. Birth date of deceased (mo., day, yr.)

Mar. 1867

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

819

hrs.

min.

9. Birthplace

St. A. Co.
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Lloyd Balloway

12. Name

St. A. Co.

13. Birthplace

Delaware

14. Maiden name

St. A.

15. Birthplace

Mary Tyler

16. Informant

251 Hanover St

Address

Burial

Date thereof

Dec. 7 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Burial

Location

Annapolis

Funeral director

Annal A. Johnson

Address

Annapolis

Date

Dec 7 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1948 at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3, 1948 1948 to Dec 3, 1948 1948

and that I last saw her alive on December 3, 1948 1948

Immediate cause of death Cardiac Failure

DURATION

Due to Hypertensive Cardio Vascular Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold H. Johnson M. D. or other

Address 40 Mulberry St Date signed 12/6/48

RECEIVED

DEC 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12136 28

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11/15/48 - 12/27/48
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 11/15/48 - 12/27/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Baltimore, Maryland County Baltimore City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1321 Presstman Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

WILLIAM LADDY THOMPSON

3. (b) Social Security Number

4. Sex MALE 5. Color or race colored 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Larace Thompson
 6.(c) If alive, give age unknown years
 7. Birth date of deceased (mo., day, yr.) 10/22/1907
 8. AGE: Year 41 Month 3 Days 4 It less than one day hr. min.

9. Birthplace North Carolina
 (Town, county, and state)
 10. Usual occupation Laborer
none
 11. Industry or business
 12. Name Calvin Thompson
 13. Birthplace North Carolina
 14. Maiden name Martha Smith
 15. Birthplace North Carolina

16. Informant Hospital Records
 Address Crownsville, Md.

Burial 12/29/48
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Mt Calvary
Md.
 Location Geo. G. Kelson

18. Funeral director 1303 Presstman St.
 Address

19. 11/28/48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/48 19 48 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/15/48 19 48 to 12/27/48 19 48

and that I last saw him alive on 12/27/48 19 48

Immediate cause of death General Paresis

DURATION known to us since 11/15/48

Due to -----

Due to -----

Other conditions 666666

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Jacob Magerstein M.D. M. D. or other

Address ----- Date signed -----

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

12137

93d

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 81 Charles St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary R. Tucker

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Samuel P. Tucker7. Birth date of deceased (mo., day, yr.) Aug 28th 1880 6.(c) If alive, give age _____ years8. AGE: Years 68 Months 3 Days 16 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual occupation home

11. Industry or business

12. Name Jos. Adam Einwachter13. Birthplace Maryland14. Maiden name Unknown

15. Birthplace

16. Informant Gordon CattertonAddress 79 Charles St. Annapolis Md.17. Burial Date thereof Dec 15th 1948
(Burial, cremation, or removal) (Which?) (month) (day) (year)Cemetery or crematory Western CemeteryLocation Baltimore Md.18. Funeral director John M. Taylor SonAddress Annapolis Md.19. 12/14/1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13th 1948 at 1:45^{PM}21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11th 1948 to Dec 13th 1948 and that I last saw him alive on Dec 13th 1948

Immediate cause of death

Coronary Thrombosis about 3 1/2 yrs.Due to C. Hypertension several yrs.Due to severe severalOther condition Hypertension years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury

Injured at work?

23. SIGNATURE Oliver PurpusAddress Annapolis Md.Date signed Dec 13/48

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

12138

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Annapolis
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Anne Arundel
City or town Riva
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME Wilbur Tucker

3. (b) Social Security Number _____

4. Sex mal 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Jan 16 - 1908 6. (c) If alive, give age _____ years

8. AGE: Years 40 Months _____ Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Edgewater and
(Town, County, and state) Laborer

10. Usual occupation _____

11. Industry or business _____

12. Name Earnest W Tucker

13. Birthplace Maryland

14. Maiden name Lillian Litch

15. Birthplace Maryland

16. Informant Earnest W Tucker

Address Riva Maryland

17. Burial Date thereof Jan 29/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory All Hallows

Location Birdsville, Md.

18. Funeral director B L Haggins & Son

Address Annapolis Maryland

19. Dec 27 19 48 Registrar W J French
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 19 48 5-10 M

21. I CERTIFY that death occurred on the date above stated Postmortem Examination

~~Other conditions~~ 19 _____

Immediate cause of death _____ DURATION _____

Due to Coronary occlusion sudden

Due to Coronary sclerosis instans

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

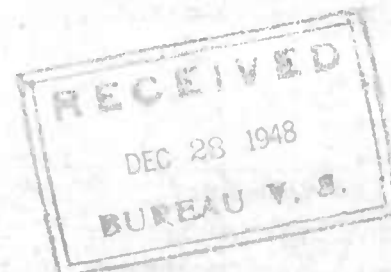
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? Deputy

23. SIGNATURE J M. Caffy M.D. Medical Examiner

Address Annapolis Md Date signed 12-24-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

12139

Reg. Dist. No.

1. PLACE OF DEATH:
 County ANNE ARUNDEL
 City or town GLEN BURNIE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MARYLAND County ANNE ARUNDEL
 City or town GLEN BURNIE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 437 CRAIN Highway N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME Auguste B. UNGERER. 3. (b) Social Security Number _____

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife William C.H. Ungerer
 6.(c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) August 19, 1888
 8. AGE: Years 60 Months 3 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace CHARLESTON S.C.
 (Town, county, and state)
 10. Usual occupation HOUSE WORK
 11. Industry or business OWN HOME.
 12. Name HENRY MEYER
 13. Birthplace CHARLESTON S.C.
 14. Maiden name HENRIETTE SCHUETTE
 15. Birthplace BYEMETHAFEN, GERMANY

18. Informant William C.H. Ungerer
 Address 437 CRAIN Highway N.E. GLEN BURNIE, MD.
 17. BURIAL Date thereof DEC. 11, 1948.
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill
 Location BROOKLYN, Md. R.F.D.
 18. Funeral director Thomas W. Loughlin
 Address Glen Burnie, Md.
 19. 12/11 19 48 L. J. Dr. Selb
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 19 48 at 8:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 9TH 8 AM 1948 to DEC. 9, 8 AM 1948
 and that I last saw him alive on Dec. 9, 1948.

Immediate cause of death Pulmonary edema DURATION 24 hrs.
 Due to pultral hemorrhage 4 da.
 Due to _____
 Other conditions Left Hemiplegia
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE F.X. Paul M. D. or other _____
 Address Glen Burnie, Md. Date signed 12/11/48

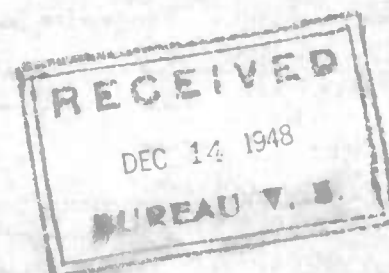
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9-45.1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

12140

93d

1. PLACE OF DEATH: **Anne Arundel**
 County.....
 City or town..... **Millersville, Md.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **30 years**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Md.** County..... **Anne Arundel**
 City or town..... **Millersville, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME **Sophia Marie Urban**
MRS. SOPHIE URBAN

3. (b) Social Security Number

4. Sex **female** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **widowed**
 6. (b) Name of husband or wife **xx Anton Urban**
 7. Birth date of deceased (mo., day, yr.) **April 27, 1868**
 8. AGE: Years Months Days If less than one day
80 hrs. min.

9. Birthplace **Czechoslovakia**
 (Town, county, and state)
 10. Usual occupation **housewife**
 11. Industry or business
 12. Name **unknown**
 13. Birthplace **II**
 14. Maiden name **II**
 15. Birthplace **II**

16. Informant **Rudolph Urban - son**
 Address **Millersville, Md.**

17. Burial Date thereof **1/2/49**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Oak Hill**
Horner's Lane, Baltimore, Md.
 Location

18. Funeral director **Schimmunek Funeral Home, Inc.**
 Address **2601-3-5 E. Madison St., Baltimore, Md.**

19. **Dec. 31** 19 **48** **A. W. Sedrick**
 (Date rec'd by registrar) 45. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **DEC. 29** 19 **48** at **10:30 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
SEPTEMBER 49 19 **48** to **December 28** 19 **48**
 and that I last saw him alive on **December 28** 19 **48**

Immediate cause of death **CONGESTIVE HEART FAILURE**

DURATION

Due to **ARTERIOSCLEROTIC HEART DISEASE**

Due to **UNKNOWN**

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Henry F. Gangara** M. D. or other
Glenn Burne S. M.D. Address Date signed **12/29/48**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

121413

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel CoCity or town Brooklyn Park
(if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
106 5th Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ma County Anne ArundelCity or town Brooklyn Park
(if outside city or town limits, write RURAL and give nearest town)Street No. 106 5th Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ANNIE OLEVIA WARD

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife William H.7. Birth date of deceased (mo., day, yr.) March 12, 1882

8. AGE: Years Months Days If less than one day

6692hrs.min.9. Birthplace Crisfield, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John Emory Tull13. Birthplace Crisfield, Md.14. Maiden name Carrie Day15. Birthplace Crisfield, Md.16. Informant William M. WardAddress 1502 Ralworth Road,17. Burial Date thereof 12/17/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Ritchie Highway A.D. Co.18. Funeral director Wm Cook Inc.Address 1217 St Paul St.19. Dec 15 48 A.W. Hedrick
(Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1948 19... at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

then after death to ... 19...

and that I last saw him alive on ... 19...

Immediate cause of death

DURATION

Coronary Occlusion
Previous history of anginal
attacks obtained from
Dr. Ernest Smith of
Johns Hopkins Hospital

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE P. J. Annibaldi M.D.Address 4609 Gen. Ritchie Hwy MA D. or other Date signed 12-15-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12142 20

1. PLACE OF DEATH:

County Prince Georges
City or town near Fairhaven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? -
Hospital, institution, or street address where death occurred: -
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Fairhaven
(If outside city or town limits, write RURAL and give nearest town)
Street No. -
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME

Vernon Le Roy Watson

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Rose Marie Watson

7. Birth date of deceased (mo., day, yr.) March 2, 1926 6.(c) If alive, give age 18 years

8. AGE: Years 22 Months 9 Days 2 If less than one day - hrs. - min.

9. Birthplace Owings Creek Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Samuel Watson

13. Birthplace Md

14. Maiden name Bertie Catterton

15. Birthplace Owings Md

16. Informant Mrs Samuel Watson

Address Fairhaven Md

17. Burial Date thereof Dec 7 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Harmony

Location Mt Harmony Md

18. Funeral director Wm H. Hutchinson

Address Owings Md

19. 12/7 19 48 M. Clayton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1948 at 2⁰⁰ p.m.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

Immediate cause of death -

Due to Fracture of skull sudden

Due to Fracture of neck sudden

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-4-48

Where did injury occur? near Fairhaven A.A. Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) lot with Co. and Fairhaven

Means of injury Auto collided with tree Injured at work? no

23. SIGNATURE John M. Claffy M.D. Deputy
M. D. or other examiner

Address Annapolis Md. Date signed 12-4-48

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12143

28

Reg. Dist. No.

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? three weeks, two days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? three weeks, two days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Georgia County... unknown
 City or town... Augusta
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... unknown
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ✓

3. (a) FULL NAME

JAMES WEST

3. (b) Social Security Number

4. Sex MALE 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Dolly West
unknown 6. (c) If alive, give age ? years
 7. Birth date of deceased (mo., day, yr.) ABT. 1872? or 1876
 8. AGE: Years 76? Months ? Days ? If less than one day
hrs. min.

9. Birthplace... Georgia
 (Town, county, and state)
 10. Usual occupation... Laborer
 11. Industry or business
 12. Name... Gordan West
 13. Birthplace... Georgia
 14. Maiden name... Emmery West
 15. Birthplace... Georgia

16. Informant... Hospital Records
 Address... Crownsville State Hospital, Md.
 17. Burial Date thereof... Dec. 20 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory... Int. Calvary
 Location... A.A. County Md.
 18. Funeral director... Rayner Sanders
 Address... 1412 E. Preston Street
 19. Dec. 16, 1948 RUC 19 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 12/16/48 19... at 1.24 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 24, 1948 to December 16, 1948
 and that I last saw him alive on 12/16/48
 Immediate cause of death... General Paresis
 DURATION
known to us since
Nov. 24, 1948
 Due to...
 Due to...
 Other conditions... Senile Psychosis known to us since
12/24/48
 (Include pregnancy within 3 months of death)
 Major findings of operations... Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury... Injured at work?
 23. SIGNATURE... Acad. Mergerson M.D.
 M. D. or other
 Address... Crownsville, Md. Date signed... 12/17/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

THOMAS TERRY WHITE

3. (b) Social Security Number

76.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mattie Louise White7. Birth date of deceased (mo., day, yr.) June 8, 1890
6.(c) If alive, give age _____ years

8. AGE:	Years	Months	Days	If less than one day
	58	6	21	hrs. min.

9. Birthplace Westwood, Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name don't know

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mrs. Mattie WhiteAddress Washington, D.C.17. Burial 1-1-49
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Trinity EpiscopalLocation Upper Marlboro, Maryland18. Funeral director Petrie BrosAddress Upper Marlboro, Maryland19. Dec 29, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29, 1948 at 7:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23, 1948 to Dec 29, 1948
and that I last saw him alive on Dec 29, 1948Immediate cause of death Cerebral hemorrhage
DURATION 4 daysDue to arterioscleroticcardiovascularDue to disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

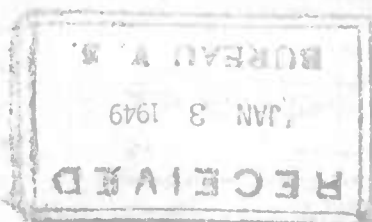
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. B. Burch M.D.
M. D. or otherAddress Annapolis Md Date signed 1.1.49/48

188 Gloucester St.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

12145

83a

1. PLACE OF DEATH:

County GarretCity or town Parole
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Parole

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County A. A.City or town Parole
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Samuel Williams

3. (b) Social Security Number

4. Sex Male5. Color or race Colored6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 10 1900

8. AGE:

Years 48

Months _____

Days _____

If less than one day

hrs. _____

min. _____

9. Birthplace West River

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business _____

FATHER

12. Name Kenby Williams13. Birthplace Ind.

MOTHER

14. Maiden name Maggie Jones15. Birthplace Ind.16. Informant Maggie WilliamsAddress Parole

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 27/48

(month) (day) (year)

Cemetery or crematorium Amapholia neckLocation A. A.18. Funeral director J. B. JonesAddress Amapholia

19. Dec 27 48

(Date rec'd by registrar)

19

Registrar J. B. Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 19 48 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 2 19 48 to Dec 21 19 48and that I last saw her alive on Dec 21 19 48

Immediate cause of death

cerebro vascular
accident

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE BT AllenM. D. or other Dr. VAddress 10 Carroll Date signed 12-27-48

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FILE NO.

RECEIVED
DEC 28 1948
BUREAU N. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

12146

1. PLACE OF DEATH:

County Anne ArundelCity or town Drownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 daysHospital, institution, or street address where death occurred:
Crownsville State HospitalHow long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2219 Hargrove Street
(If rural, give LOCATION)2.(a) If veteran, name war ***** ✓

3. (a) FULL NAME

HARRY WINTERS

3. (b) Social Security Number

4. Sex Male 5. Color or race colored B.(a) Single, married, widowed, or divorced single6.(b) Name of husband or wife *****7. Birth date of deceased (mo., day, yr.) ***** B.(c) If alive, give age ***** years
ABT. 19058. AGE: Years 43 Months **** Days ** If less than one day ** hrs. ** min.9. Birthplace Maryland (town unknown)
(Town, county, and state)10. Usual occupation laborer
none

11. Industry or business

12. Name Franklin Winters13. Birthplace Maryland14. Maiden name Catherine --last name unknown15. Birthplace unknown16. Informant Hospital RecordsAddress Crownsville, Maryland17. Burial Date thereof Jan 3, 1949
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory 3rd Mt Calvary CemLocation A. A. Co.18. Funeral director Layner SampsonAddress 1412 E. Preston Street19. 1/3 X9 AW Hedrick
(Date filed by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30/48 19 48 at 12:58P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12/23/48 19 48 to 12/30/48 19 48and that I last saw him in alive on 12/30/48 19 48Immediate cause of death General Paresis
Alcoholic PsychosisDURATION
known to
us since
12/23/48

Due to

Due to

Other conditions *****

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results *****

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ***** Date of *****Where did injury occur? *****
(City or town) ***** (State)Injured at home, farm, industry, public place (where?) *****Means of injury ***** Injured at work?23. SIGNATURE Jacob Hargrove M. D. or otherAddress ***** Date signed *****

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12147 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

United States Naval HospitalHow long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town nr Annapolis RURAL
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 SEVEN WALK Woodland Beach
(If rural, give LOCATION)WW II

2.(a) If veteran, name war

3. (a) FULL NAME

JEROME (NONE) ZAVADIL
(last name)

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife ANNA7. Birth date of deceased (mo., day, yr.) 05-01-03 6.(c) If alive, give age 43 years8. AGE: Years 45 Months 09 Days 26 If less than one day
.....hrs.min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Musician (Navy)11. Industry or business Musician12. Name Joseph Zavadil13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Navy RecordsAddress USNAVBKS. (USS REINA MERCEDES)17. Burial Date thereof Dec. 30, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Ben L. Hopping and SonAddress 170-172 West St. Annapolis, Maryland19. Dec. 30 19 48
(Date rec'd by registrar)

W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 48 at 9:02P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
pt. dead on arrival to 19and that I last saw him alive on pt. dead on arrival 19Immediate cause of death HEMORRHAGE, Pancreaticoduodenal artery DURATION
MinutesDue to ULCER, Peptic, Duodenum Unknown

Due to

Other conditions CARCINOMA, Head of Pancreas; Laennec's Cirrhosis; Abscess Peritoneum
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? DeathSignature John M. Claff M.D. Medical ExaminerAddress Annapolis, Md M. D. or otherDate signed 12-29-48

RECEIVED

JAN 3 1949

BUREAU V. S.